I. Other Requirements

Technical Reporting Requirements

Provide CDC with original plus two copies of:

1. Quarterly progress reports. (The progress report will include a data requirement that demonstrates measures of effectiveness.)

2. Financial status report, no more than 90 days after the end of the budget period.

3. Final financial status and performance reports, no more than 90 days after the end of the project period.

Send all reports to the Grants Management Specialist identified in the ''Where to Obtain Additional Information'' section of this announcement.

The following additional requirements are applicable to this program. For a complete description of each, see Attachment 1 of the application kit.

AR–9 Paperwork Reduction Act Requirements

AR–10 Smoke-Free Workplace Requirements

AR–11 Healthy People 2010

AR–12 Lobbying Restrictions

AR–13 Prohibition on Use of CDC Funds for Certain Gun Control Activities

AR–14 Accounting System Requirements

AR–15 Proof of Non-Profit Status

J. Where To Obtain Additional Information

This and other CDC announcements, the necessary applications, and associated forms can be found on the CDC home page Internet address—*http://www.cdc.gov* Click on ''Funding'' then ''Grants and Cooperative Agreements.''

For business management assistance, contact: Van A. King, Grants Management Specialist, Procurement and Grants Office, Centers for Disease Control and Prevention, 2920 Brandywine Road, Room 3000, Atlanta, GA 30341–4146, Telephone number (770) 488–2751, email address: *vbk5@cdc.gov.*

For program technical assistance, contact: Doug Browne, Project Officer, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway, Mailstop F–41, Atlanta, GA 30341, Telephone number (770) 488–1569, email address: *drb7@cdc.gov.*

Dated: June 21, 2002.

Sandra R. Manning,

CGFM, Director, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 02–16234 Filed 6–27–02; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2155–PN]

Medicare and Medicaid Programs; Application by the Accreditation Association for Ambulatory Health Care, Inc. for Continued Deeming Authority for Ambulatory Surgical Centers

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of a renewal application by the Accreditation Association for Ambulatory Health Care, Inc. for continued recognition as a national accreditation program for ambulatory surgical centers that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act requires that within 60 days of receipt of an organization's complete application we publish a proposed notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on July 29, 2002.

ADDRESSES: In commenting, please refer to file code CMS–2155–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (1 original and 3 copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2155–PN, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (1 original and 3 copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses identified for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Milonda Mitchell, (410) 786–3511.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7197.

Copies: Additional copies of the **Federal Register** containing this proposed notice can be made at most libraries designated as Federal Depository libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The web site address is: *http://www.access.gpo.gov /nara/index.html.*

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in an ambulatory surgical center (ASC) provided the ASC meets certain requirements. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) authorizes the Secretary to establish distinct criteria for facilities seeking designation as an ASC. Under this authority, the Secretary has set forth in regulations minimum requirements that an ASC must meet to participate in Medicare. The regulations at title 42, part 416 (Ambulatory Surgical Services) of the Code of Federal Regulations (CFR)

determine the basis and scope of covered services provided by an ASC, and Conditions for Medicare payment for ASCs. Applicable regulations concerning provider agreements are at part 489 (Provider Agreements and Supplier Approval) and those pertaining to the survey and certification of facilities are at part 488 (Survey Certification and Enforcement Procedures), subpart A (General Provisions) and B (Special Requirements).

In order for an ASC to be approved for participation in the Medicare program, the ASC must comply with State licensure requirements. The ASC must be certified by a State survey agency as complying with the conditions or requirements, as set forth in § 416.26(b) of our regulations. Then, the ASC is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(b)(1) of the Act permits provider entities that are accredited by CMS-approved accrediting organizations to be exempt from routine surveys by State survey agencies to determine compliance with Medicare conditions of coverage. Accreditation by an accreditation organization is voluntary and is not required of ASCs for Medicare participation. Section 1865(b)(1) of the Act provides that, if an ASC demonstrates through accreditation that all applicable Medicare conditions are met or exceeded, we shall ''deem'' those ASCs as having met the requirements.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 488, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning renewal of an accreditation organization's deeming authority are set forth at §§ 488.4 and 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years or sooner, as determined by us. Our current recognition of the Accreditation Association for Ambulatory Health Care Inc.'s (AAAHC) accreditation program for ASCs will terminate on December 19, 2002.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act requires that our findings concerning review of a national accrediting organization's requirements consider, among other factors, the reapplying accreditation organization's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from our receipt to publish approval or denial of the application.

The purpose of this proposed notice is to inform the public of our receipt of the AAAHC's request for renewal and continuation of its deeming authority for ASCs. This notice also solicits public comment on the ability of AAAHC requirements to meet or exceed the Medicare conditions for coverage for ASCs.

II. Evaluation of Deeming Authority Request

On April 18, 2002, AAAHC submitted all the necessary materials concerning its request for renewal as a deeming organization for ASCs to enable us to make a determination. Under section 1865(b)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation organizations), our review and evaluation of AAAHC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AAAHC standards for an ASC as compared with our comparable ASC conditions of coverage.
- AAAHC's survey process to determine the following:

—The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

—The comparability of AAAHC's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

—AAHC's processes and procedures for monitoring providers or suppliers found out of compliance with AAAHC's program requirements. These monitoring procedures are used only when AAAHC identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified at § 488.7(d).

—AAAHC's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

—AAAHC's capacity to provide us with electronic data in ASCII comparable code, and reports necessary for effective validation and assessment of the organization's survey process.

—The adequacy of AAAHC's staff and other resources, and its financial viability.

—AAAHC's capacity to adequately fund required surveys.

—AAAHC's policies with respect to whether surveys are announced or unannounced.

—AAAHC's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Response to Comments and Notice Upon Completion of Evaluation

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all public comments we receive by the date and time specified in the **DATES** section of this preamble, and when we proceed with a final notice, we will respond to the public comments in the preamble to the document.

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this proposed notice.

In accordance with Executive Order 13132, we have determined that this proposed notice would not have a significant effect on the rights, roles, and responsibilities of States, local, or tribal governments.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb)

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 19, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–15969 Filed 6–27–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2154–PN]

Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organizations for Continued Deeming Authority for Ambulatory Surgical Centers

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Joint Commission on Accreditation of Healthcare Organization for continued recognition as a national accreditation program for Ambulatory Surgical Centers that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act requires that within 60 days of receipt of an organization's complete application, we publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on July 29, 2002.

ADDRESSES: In commenting, please refer to file code CMS–2154–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (1 original and 3 copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2154–PN, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (1 original and 3 copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses identified for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 786–0310.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7197.

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This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The web site address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in an ambulatory surgical center (ASC) provided certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) authorizes the Secretary to establish distinct criteria for facilities seeking designation as an ASC. Regulations concerning supplier agreements are at title 42, part 489 of the Code of Federal Regulations (CFR) and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at part 416 specify the conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for facility services.

Generally, in order to enter into an agreement, an ASC must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 416 of our regulations. Then, the ASC is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation that all applicable Medicare conditions are met or exceeded, we shall ''deem'' those provider entities as having met the requirements. Accreditation by an accreditation organization is voluntary and is not required for Medicare participation.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 488, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning reapproval of accrediting organizations are set forth at §§ 488.4 and 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years or sooner, as determined by us.

The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) current term of approval as a recognized accreditation program for ASCs expires December 19, 2002.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and reapproval of a national accrediting organization's requirements consider, among other factors, the reapplying accreditation organization's